Oppositional defiant disorder and conduct disorder: different names for the same condition?

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Abstract
The purpose of this paper is to present a review of the literature related to the proposition that oppositional defiant disorder and conduct disorder are, in essence, the same disorder, with varying degrees of severity. The author of this paper believes that it would make more sense diagnostically to combine these two diagnoses into one category.

This paper will cover a variety of areas related to oppositional defiant disorder and conduct disorder. First, a section on the formulation of the diagnostic criteria is presented. Brief definitions and descriptions of the two disorders follow the diagnostic criteria section. In addition to these two sections, there are sections that cover methods for distinguishing classifications and the progression of the developmental relationship between oppositional defiant disorder and conduct disorder. In closing, a case illustration, discussion and conclusion section are provided. The author will also describe a proposed new diagnostic classification—oppositional conduct disorder.
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The discriminating behaviors used to establish the diagnostic criteria for the disruptive behavior disorders (American Psychiatric Association, 1991) have raised considerable concerns about the diagnostic formulations. The current literature seems to suggest that both oppositional defiant disorder and conduct disorder are strongly and developmentally related (Loeber, Lahey, & Thomas, 1991; Schachar & Wachsmuth, 1990). Lahey, Loeber, Quay, Frick, and Grimm (1992) reported that, in almost all cases of clinically referred individuals with the onset of conduct disorder before puberty, the individuals had retained the symptoms of oppositional defiant disorder that were present at earlier ages.

The purpose of this paper is to present a review of the literature related to the proposition that oppositional defiant disorder and conduct disorder are, in essence, the same disorder, with varying degrees of severity. The author of this paper believes that it would make more sense diagnostically to combine these two diagnoses into one category.

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Formulation of the Diagnostic Criteria

The American Psychiatric Association (APA) conducted meetings to identify proposed options for the new criteria for both oppositional defiant disorder and conduct disorder in the DSM-IV (American Psychiatric Association, 1994). The authors of the DSM-IV (American Psychiatric Association, 1994) wanted the descriptions and diagnostic criteria to have the same wide acceptance as the DSM-III-R (American Psychiatric Association, 1987). A set of possible symptoms were assembled, and a final list was selected (McBurnett,
Lahey, & Pfiffner, 1993). This descriptive process requires the consideration of several factors in the selection of optimal diagnostic criteria (Frick, Lahey, Applegate et al., 1994). The list of criteria are usually used by clinicians as a means of making the distinction between the various disorders in order to determine the appropriate diagnosis.

The first step to improve the reliability and validity of any diagnosis is to eliminate the symptoms that are only weakly associated with that specific disorder (Frick et al., 1994). In addition to this process of improving the reliability and validity, alternative ways of defining symptoms are assessed (Frick et al., 1994). Waldman and Lilienfeld (1991) found that an overlap existed between behaviors described in the two disorders. At any rate, there have been many attempts to clarify distinguishing characteristics between disruptive behavior disorders.

Definitions

Disruptive behavior disorders are included in the domain of childhood externalizing disorders. Externalizing childhood disorders are those behaviors that are readily observable, when the child “acts out”
(e.g. continuous talking, stealing, refusing to follow directions.) This acting out may consist of pervasive conduct problems, impulsiveness, aggression or delinquency (Barkley, DuPaul, & McMurray, 1990). These disorders are characterized by behavior that is socially disruptive. According to the Diagnostic and Statistical Manual of Mental Disorders (3rd ed. rev.) (American Psychiatric Association, 1987), these behaviors cause more distress to others than to the individual diagnosed or suffering from the disorder. Oppositional defiant disorder (ODD) and conduct disorder (CD) are both categorized within the realm of disruptive behavior disorders.

Oppositional defiant disorder, as defined by DSM-III (American Psychiatric Association, 1980), is described as an enduring pattern of oppositional, irritable, and stubborn behavior. In addition, Loeber, Lahey, and Thomas (1991) wrote that bullying and fighting are considered symptoms of oppositional defiant disorder. The Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (American Psychiatric Association, 1994) listed "negativistic, defiant, disobedient, and hostile behaviors" (p. 91) as
essential features of oppositional defiant disorder. The diagnosis of oppositional defiant disorder is best applied when there is a pattern of disobedience, negativism, and the opposition to authority figures (Schachar & Wachsmuth, 1990). Truancy, violating household curfews and non-aggressive behaviors (such as threatening others and temper tantrums) are examples of symptoms that do not violate the rights of others, but do constitute opposition to authority.

The conduct disorder diagnosis, according to the DSM-III (American Psychiatric Association, 1980), consists of more serious violations of the rights of others and societal norms. Conduct disorder is often characterized by theft, gang membership and loyalty to delinquent friends, and property destruction.

Many mental health professionals use different labels for children diagnosed with conduct disorder. School psychologists often define these children as "aggressive." Educators and pediatricians may view them as "children living with a learning disability and hyperactivity." Criminologists frequently define these cases as "delinquents" (Robins, 1991).
Oppositional Defiant Disorder

Methods for Differentiating Classifications

The diagnosis of oppositional defiant disorder has received criticism since some investigators wonder if the specific displayed behaviors are severe enough to distinguish these children from normal children (Lahey et al., 1992; Loeber, et al., 1991; Schachar & Wachsmuth, 1990). The literature reveals a number of methods for distinguishing classifications, including those of Lahey et al. (1992) and Loeber et al. (1991).

Lahey et al. (1992) suggested that a multilevel conceptualization combining oppositional defiant disorder and conduct disorder is an innovative approach. The first level would primarily consist of symptoms of oppositional defiant disorder. The second level would consist of symptoms associated with conduct disorder. These were symptoms such as fighting, lying and stealing. The third level would consist of more confrontational symptoms that typically emerged later. Breaking and entering into a home, physical cruelty and theft would characterize this final level.

Loeber et al. (1991) suggested using a statistical cluster technique that would determine a difference in possible subtypes of disruptive behavior disorder.
Three clusters were identified. The clusters were labeled as: (a) socialized cooperative delinquents, (b) unsocialized aggressive delinquents, and (c) unsocialized runaway delinquents. The first grouping was characterized by thefts and associations with companions that seemed undesirable (i.e., gang activity). Non-compliance, assaultive behaviors, argumentativeness, inappropriate acting out (i.e., yelling, stomping of feet) and destruction of property described those individuals classified in the unsocialized aggressive delinquents cluster. The grouping, unsocialized runaway delinquents, are characterized by staying out late at night, running away from home, lying about whereabouts, and stealing (Loeber et al., 1991).

Loeber, Lahey, and Thomas (1991) indicated that disagreements about the nature and subclassification of disruptive behavior disorders reflect different approaches to studying the disorders. According to these different perspectives, the possible distinction between oppositional defiant and conduct disorders can be determined in a number of ways: (a) the diagnostic categories may be entirely distinct entities (Loeber et
Oppositional Defiant Disorder

al., 1991); (b) restricted definitions could increase the distinction between the two diagnostic categories (Frick et al., 1994); (c) oppositional defiant disorder can be viewed as a variant of normality or a variant of conduct disorder (Schachar & Wachsmuth, 1990); or (d) a diagnostic criterion that has a clearer relationship to functional impairment should be added to the definitions of these disorders. (McBurnett, Lahey, & Pfiffner, 1993).

Some authors believe that oppositional defiant disorder may be a separate and distinct disorder from conduct disorder (Loeber et al., 1991). The developmental course of many oppositional defiant disorder symptoms seems different from that of conduct disorders. Currently, there are no specific guidelines in diagnosing oppositional defiant behavior in early childhood. Oppositional defiant disorder symptoms often emerge in the preschool period when the behaviors may be viewed as normal and not connected to psychopathology.

Frick et al. (1994) seemed to believe that the DSM-IV should deliver more definitive language in regards to the differences in diagnoses between
oppositional defiant disorder and conduct disorder. The authors argued that even if the disorders are related, the language may still need be distinct enough to more appropriately conceptualize them. One example of a possible change is that the language could include describing whether the age of onset was “early” or “late.” Early onset, although precursors may appear in early childhood, typically begins by eight years of age. Late onset typically occurs prepubertal. The pubertal years usually refer to 14-year old males and 12-year old females, as noted in Table 1.

The behaviors of normal children may resemble the behaviors of a child diagnosed with oppositional defiant disorder (Schachar & Wachsmuth, 1990). In some instances, behaviors associated with oppositional defiant disorder seemed like behaviors many non-diagnosed children display. Displaying temper tantrums and stubbornness, refusing to do chores, lying, and playground fighting may seem like behaviors of normal children rather than symptoms of a psychiatric disorder. More aggressive symptoms appear related to conduct disorder diagnosis. Constant fighting or physical aggression, especially when the act involves a
weapon, could demonstrate a transition from normality to pathology. These behaviors, according to the severity of impairment, may need to be viewed as a variant of oppositional defiant disorder.

Another way to consider the relationship between the two disorders is to conceptualize them as sharing certain core negative behaviors, but existing on a continuum of functional impairment (McBurnett et al., 1993). For example, nonaggressive behaviors displayed by a child with oppositional defiant disorder may hinder the academic success of the child. Truancy, argumentativeness, talking in class, lack of impulse control, sleeping in class and bullying other students may impact the child’s ability to learn within the classroom. On the other hand, aggressive behaviors displayed by a child with conduct disorder may infringe on the rights of others to learn. Threatening students, fighting students, and destructing school property disrupts the educational environment. The difference in functional impairment between these two ends of the continuum could dictate diverse interventions (McBurnett et al., 1993).
The inability to definitively distinguish between the symptoms of the two disorders has greatly affected the assessment studies. The disagreements are evident in assessments. Assessment studies are usually based on rating scales that identify patterns due to oppositional defiant disorder, conduct disorder and attention-deficit hyperactivity disorder (Biederman et al., 1996). The Conners Teacher Rating Scale (CTRS), the Child Behavior Checklist (CBCL), the Behavior Problem Checklist are useful aids in the diagnostic process for child psychopathology (Pelham, Evans, Gnagy, & Greenslade, 1992). For an example of this approach, see table 2.

The symptoms for disruptive child behavior (such as those exhibited by youth diagnosed as oppositional defiant and conduct disordered) consistently split into two groupings. The two groupings were labeled aggressive symptoms and delinquent symptoms (Frick et al., 1994). The first list of symptoms consisted of inattention and disorganization (Frick et al., 1994). Schachar and Wachsmuth (1990) listed "argumentativeness, provocative behavior, and violations of minor rules" (p.1091) as symptoms
consistent with this first grouping. In addition to these symptoms, both oppositional defiant disorder and conduct disorder encompass covert antisocial acts. These acts include vandalizing and stealing. It is likely that more serious physical aggression, overt symptoms, such as a "bully" or mean and nasty acts towards other children correlate strongly with conduct disorder (Lahey, Loeber, Quay, Frick, & Grimm, 1992; Loeber et al., 1991; Spitzer, Davies, & Barkley, 1990, 1992). The overt symptoms would seem to indicate a diagnosis of conduct disorder rather than an oppositional defiant disorder diagnosis. Yet, an oppositional defiant disorder diagnosis may suffice since both diagnosis list overlapping symptoms, such as fighting.

Loeber et al. (1991) described two different dimensions of disruptive behaviors. The two dimensions seemed to occupy opposite poles of a diagnostic continuum, although there are unifying qualities across the diagnoses. Oppositional defiant disorder is towards one end and conduct disorder represents the other end. One dimension of behaviors consisted of disobedience, attention seeking behaviors, bullying and
dominating others, and physical fighting. The second dimension included stealing, running away from home, associating with bad companions, and lying.

The first dimension composed all these symptoms associated with oppositional defiant disorder, but also included the aggressive behaviors that are associated with conduct disorder. The unifying quality of these different diagnoses is that the described symptoms involve overt hostile confrontation with another person, thus violating the other person's rights. Conversely, the second dimension consisted of all the symptoms of conduct disorder that involve nonaggressive acts.

These dimensions suggest an overlap, as illustrated by Table 3, in symptomatology. The factor labeled as violating the rights of others or aggressive behaviors, fighting and bullying, included symptoms of oppositional defiant disorder. The delinquent factor of conduct disorder was composed of covert symptoms, such as vandalism (Loeber et al., 1991). Other examples of covert symptoms may include truancy from school, lying and violating or breaking curfew (at home.)
Oppositional Defiant Disorder

Relationship and Developmental Progress of the Disorders

The author believes youths who exhibit conduct disorder will also exhibit the symptomatology of oppositional defiant disorder. According to Spitzer, Davies, and Barkley (1990), a high degree of comorbidity between the group of disruptive behavior disorders. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) distinguishes patterns of disruptive behavior that appear to differ in severity. The current literature about oppositional defiant disorder and conduct disorder also establishes a progression from oppositional defiant disorder to conduct disorder (Lahey et al., 1992) and suggests that the disruptive disorders (especially oppositional defiant disorder) are observed in association with other disruptive behavior disorder (Spitzer et al., 1990). Loeber, Lahey, and Thomas (1991) concluded that: "the prevalence of both fighting and lying in the oppositional defiant disorder group was significantly less than the conduct disorder group, but was greater than the clinic control group" (p.382). Consequently,
this relationship between conduct disorder and oppositional defiant disorder could be a function of human development, with youths moving from oppositional defiant disorder to conduct disorder as they get older.

The possibility of a developmental progression from oppositional defiant disorder to conduct disorder can be evaluated. Schachar and Wachsmuth (1990) proposed that oppositional defiant disorder was a variant of conduct disorder. This research compared normal controls against subjects with oppositional defiant disorder and conduct disorder to determine whether oppositional defiant disorder was, in fact, a distinct disorder. They contended that oppositional defiant disorder is a variant of conduct.

Loeber et al. (1991) stated that the mean age of onset for oppositional defiant disorder is earlier than when the symptoms of conduct disorder are usually exhibited. Furthermore, Loeber et al. (1991) wrote, "it is probably the case that oppositional defiant disorder preceded the onset of conduct disorder" (p.387). Frick et al. (1994) noted that one conduct disorder symptom ("initiates physical fights") was an indicator of a diagnosis of oppositional defiant
Oppositional Defiant Disorder

disorder. These studies seem to indicate that a development progression exists between oppositional defiant disorder and conduct disorder.

The course of the developmental progression between oppositional defiant disorder and conduct disorder varies. Many children diagnosed with oppositional defiant disorder achieve reasonable social and occupational adjustment as adolescents and adults. That is, in many cases, individuals who exhibit oppositional defiant disorder do not later develop conduct disorder. Although there may be exceptions, it is believed that early successful intervention has the greatest impact against the progression from oppositional defiant disorder to conduct disorder and beyond (Lahey et al., 1992).

With other individuals, the developmental progression of these disorders may even persist into adulthood. There may be adequate social functioning in adulthood, but persistence of illegal activity may be diagnosed as adult antisocial behavior (V Code). Even worse, many mental health professionals indicate that without successful intervention, there is a greater risk of continuation or progression into adult life as
Oppositional Defiant Disorder


The following is a case study of a child who did not receive successful intervention at an early stage. The case study is an illustration of a child who progressed from exhibiting symptoms of oppositional defiant disorder to developing symptoms of conduct disorder. The illustration consists of information from family interviews and information about past and present concerns.

Case Illustration

“Trent” was a 14-year old eighth grade male student at a junior high school in a nearby school district. He was the second of two children of biological parents with whom he resides. Both parents were gainfully employed.

Family Interview

The primary concerns for Trent were of a behavioral nature. These concerns were centered around the teenager’s impulsiveness, non-compliance, and relationship issues within the immediate family. These concerns seemed to have intensified over the years. During the past 4-6 years, despite the patient and the
Oppositional Defiant Disorder

family receiving assistance from a number of mental health providers, life was described as "a living hell" in the family interviews.

The parents expressed a high level of frustration, stress and disappointment when discussing their attempts to manage Trent's behavior. The older brother, "Aaron," stated that the frequency ("everyday") was becoming intolerable and that "nothing seems to work." The father described Trent’s behavior as "volatile."

On one occasion the family was watching television, and Trent became upset when the family decided to watch a television program that he did not want to see. Trent not only became boisterous and loud, he also threw a chair through a glass door.

The family reported that during those times when Trent became aggressive and destructive, he also became physically aggressive towards other family members. The parents indicated that these acts led to physical altercations with the family members who were "trying to restrain him."

In addition to the physical interventions, the mother noted that she tried to "talk with him." She
described her method as tactics to distract Trent because she feared that there would come a time when she was alone at home and he "goes out of control."
The mother showed her fear and wept when she explained her verbal attempts to interrupt the teenager's acting out behavior. The family admitted that the use of behavior techniques to modify the "explosive" behavior did not exist in the household. The mother told of her confusion that her child showed no signs of "being sorry" for the actions after he did them. The family agreed that there was no apparent indications that Trent was remorseful or apologetic nor did he outwardly exhibit signs of guilt.

As the interview continued, the mother discussed more about Trent's behavior at home. She continued with descriptions of his temper outbursts, belief in entitlements, and his overwhelming demanding nature. When discussing his temper, she said that he "goes crazy for nothing." She reported that his outbursts come in two distinct types. One type seemed to be "almost spontaneous," (i.e. yelling at the dinner table) and the other seemed "to build like a slow,
The father entered into the discussion. He contended that Trent wanted “control of the house” and attempted to tell his mother what to do. Trent constantly reviewed family rules for acts of unfairness and reacted with a burst of uncontrollable rage. This uncontrollable rage, as previously reported, ultimately resulted in an attempt to physically restrain the youth.

The older sibling, Aaron, reported that there was no consistent pattern in Trent’s outbursts of anger. The episodes apparently had no specific precursor. He described the episodes as “unpredictable.”

Trent acknowledged his difficulties, but stated that he was not acting out because he was worried (anxious) or sad (depressed) over any particular situations. He stated that he knew that he acted out, but tended to blame his behavior on someone else or their actions. He admitted having been physically restrained because of the way he responded to the house rules, but contended that this only happened “when his parents treated him unfairly” or because his brother
"gets away with murder." He said that his parents were unfair and did not listen to his side of the story and that "if someone gets hurt when I am out of control then it is nobody’s fault but their own.” Interestingly, he also admitted feeling “loved and welcomed” in the family.

Trent, reported that he slept “okay,” had a healthy appetite, and got enough sleep. He admitted that he was sleepy during the day and that he did not see a need to play outside. He liked video games, his “Giga Sumo Wrestler” (a “virtual” person), and math.

Past Concerns

In terms of Trent’s behavior before these more recent episodes, when his behavior had escalated to a physical nature, the parents reported a more “oppositional attitude.” The parents agreed that, at age ten, Trent was not very trusting or believing in anyone. At this early age, the parents realized the “the only way to get along with Trent” was to do whatever he said and to give him whatever he wanted.

The parents explained that setting limits, boundaries and ground rules with consequences had never been a problem in the household. However, following
through on the limitations was an issue that needed to be addressed. Trent's mother spoke of a number of times that she and her husband "gave in" to Trent. This meant that Trent never really had to deal with the consequences of his inappropriate behaviors. Trent would "storm out" or "simply leave the room" whenever the parents attempted to enforce a consequence. At age 11, Trent stated "he wanted to be the parent." He would attempt to boss everyone in the family. Trent's attempts seemed to leave the mother in a state of confusion and very frustrated. She often became overwhelmed and would "simply cry." Family kindness and courteousness had no apparent significance on Trent. He continued to lie, throw temper tantrums and refused to go to school. During these early ages, Trent began "manipulating us because we were not always on the same page for verbal reprimands and consequences."

**Presenting Concern**

Trent has had a history of exhibiting "explosive" behaviors and displaying acts of physical aggression. The frequency of these incidents had increased over the past 4 to 6 years. The intensity of his outbursts were
"frightening" to those who had witnessed them. Trent was recently detained by city police officers at the neighborhood “Boys and Girls Club.” He was throwing chairs after tipping the pool table onto its side. He also threw the pool balls and damaged some property.

This incident resulted in an evaluation period of two weeks at the adolescent mental health unit located within a community hospital because Trent also became unmanageable at home. Trent was admitted to the unit because he was making extremely angry outbursts and was injuring himself and his parents. While at the adolescent unit, Trent was physically restrained four times during a 24 hour period because of property damage and being assaultive toward other patients and staff members.

Trent had experienced a difficult time managing his behavior at school. He was in a self-contained classroom because of “episodes within the building.” Trent was recently reinstated into school. He served a suspension prior to the incident at the Boys and Girls Club because of a physical assault against another student.
Discussion

This case illustration depicts a child diagnosed with conduct disorder. The author has compared the information gathered in the family interviews to the definitions, methods for classifications, and the developmental progression of oppositional defiant disorder and conduct disorder.

At an early age, the child began displaying behaviors that some may consider normal. Limit testing, noncompliance and minor violations of house rules, to mention a few, were evident. However, these behaviors may have been the early symptoms of the onset of oppositional defiant disorder.

The child’s behavior caused stress in the lives of the parents. The negativistic and disobedient behaviors frustrated the mother, the father, and the older brother. The lying, violating of household rules, and having temper tantrums were well within the dimension of nonaggressive behaviors that characterize oppositional defiant disorder. Although these behaviors were nonaggressive, the child seemed to have started violating the rights of others as his behavior escalated.
Over the years, the child’s behavior became unmanageable. The explosive nature of the child’s behavior seemed to overwhelm the family structure. The negativistic and hostile behaviors ended in physical altercations between father and son. It was at this point that the family seemed to realize that the child could damage property, injure others and himself and show no signs of remorse.

As the list of inappropriate behaviors mounted, the disruptive behaviors were also evident in the community. Behaviors that once seemed almost normal had escalated into pathology. The child was not “fighting” peers, but “assaulting” others.

The case study illustrated the progression from oppositional defiant disorder to conduct disorder. The child’s functioning level within the family, school and community was deteriorating. The impairment became greater as the child’s behavior went from normalcy to pathology.
Oppositional Defiant Disorder

Proposing a New Diagnosis

The author would like to propose "oppositional conduct disorder," a new diagnostic category that combine elements of oppositional defiant disorder and conduct disorder. The diagnosis of oppositional conduct disorder (OCD) would be considered when the essential features range between a persistent pattern of negativistic, hostile, and defiant behavior in which the basic rights of others are violated. The behavior pattern typically would be present in the home, at the school, and in the community. The diagnosis would be made only when the pattern of oppositional behavior is more apparent than that seen in other persons of the same mental age. The degree of impairment would range from mild to severe.

Mild

The child with this degree of the disorder commonly would be argumentative with adults, defy authority, are often angry, swear, and are easily annoyed by others. The child would blame others for
his or her own mistakes or difficulties. The manifestations of the disorder would be almost always present in the home and with adults or peers whom the child knows well.

**Moderate**

With a moderate degree of impairment of oppositional conduct disorder, lying, cheating and covert stealing would be common. The child might either "borrow" someone else's belongings or engage in shoplifting and breaking and entering into a home, building, or car. This child would often be truant from school and may run away from home. The child would often lose his or her temper. Usually this child would not see his or her behavior as negative, but would rather justify his or her behavior as a response to unfair treatment, situations, or circumstances.

**Severe**

With a diagnosis of severe oppositional conduct disorder the behaviors would be overt. Physical aggression and property destruction would be common.
This child or adolescent might initiate aggression, be cruel to people or animals and frequently deliberately destroy property (this behavior may include fire-setting). The stealing would not be of a covert nature. The individual may engage in purse snatches, car-jacks, armed robberies, and extortions. The later ages may be characterized by violence in the form of a rape, an assault or even a homicide.

The associated features vary as a function of age. The child usually would have no concern for the feelings or well-being of others. Poor self-concept and low frustration tolerance may contribute to the illicit drug use, alcohol use, or tobacco use which would be common. The child may lack appropriate feelings of guilt or remorse. This child may inform on his or her companions (considered "tattling" at young ages and "snitching" at older ages) and display temper outbursts at home and in the school. While early onset for this diagnosis is usually by age seven, late onset may occur prepubertal or postpubertal.
Conclusion

One of the main reasons that oppositional defiant disorder may be used as a variant of conduct disorder is the relationship of the symptoms to the degree of impairment. The criteria that establishes the rule that the diagnosis of oppositional defiant disorder is excluded if conduct disorder is present seems to validate the idea that oppositional defiant disorder is a less severe form of conduct disorder within the domain of the disruptive behavior disorders. Schachar and Wachsmuth (1990) concluded that oppositional defiant disorder and conduct disorder did not have differential validity in either their study or the previous existing research. This suggests that a distinction between oppositional defiant disorder and conduct disorder may not be necessary. Lahey, Loeber, Quay, Frick and Grimm (1992) decided that their research findings indicated that oppositional defiant disorder and conduct disorder could be viewed as the
same disorder that is developmentally staged into hierarchical levels of severity.

In conclusion, the *Diagnostic Statistical Manual for Mental Disorders (DSM-IV)* has subclassified the two disorders as different. However, the two disorders are classified as developmentally related. Loeber, Lahey, and Thomas (1991) indicated, "a classification system eventually needs to address the possible groupings and descriptions of symptoms considered part of the disorder..." (p. 388). The author has made an attempt to do this with his proposal for the new diagnostic classification, oppositional conduct disorder.
### Table 1. An Example of the Median Age of Early Onset and Late Onset

<table>
<thead>
<tr>
<th>Mean age</th>
<th>Oppositional</th>
<th>Conduct Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0</td>
<td>Stubborn</td>
<td></td>
</tr>
<tr>
<td>5.0</td>
<td>Loses temper, defies</td>
<td>Hurts animals</td>
</tr>
<tr>
<td>6.0</td>
<td>Argues</td>
<td></td>
</tr>
<tr>
<td>7.0</td>
<td>Blames, annoys others, spiteful</td>
<td>Fights, lies</td>
</tr>
<tr>
<td>8.0</td>
<td>Angry, resentful</td>
<td>threatens others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>uses weapons</td>
</tr>
<tr>
<td>9.0</td>
<td>Swears</td>
<td>Starts fires,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>destruction of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>property</td>
</tr>
<tr>
<td>10.0</td>
<td>Gang affiliation</td>
<td>Truant</td>
</tr>
<tr>
<td>11.0</td>
<td></td>
<td>Breaks and</td>
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<tr>
<td></td>
<td></td>
<td>enters</td>
</tr>
<tr>
<td>12.0</td>
<td></td>
<td>Runs away from</td>
</tr>
<tr>
<td></td>
<td></td>
<td>home</td>
</tr>
<tr>
<td>13.0</td>
<td></td>
<td>Forces sex</td>
</tr>
</tbody>
</table>

(Lahey et al., 1992, p. 539)
Table 2. An Example of a Baseline and Follow-up Assessment using the Child Behavior Checklist (CBCL)

(Biederman et al., 1996, p. 1199)
Table 3. An Example of Results From the Meta-Analysis of Factor Analyses of Disruptive Child Behavior

**Table 3. An Example of Results From the Meta-Analysis of Factor Analyses of Disruptive Child Behavior**

**A. Property Violations**
- Cruel to animals *
- Steals *
- Firesetting *
- Lies *

**B. Aggression**
- Assault
- Spiteful
- Cruel
- Blames others
- Fights
- Bully

**C. Status Violations**
- Runaway *
- Breaks rules *
- Truancy *
- Substance use *

**D. Oppositional**
- Touchy
- Stubborn

(Loeber, Lahey, & Thomas, 1991, p. 382)
Oppositional Defiant Disorder

References


Oppositional Defiant Disorder


McBurnett, K., Lahey, B., & Pfiffner, L. (1993). Diagnosis of attention deficit disorders in DSM-IV:
Oppositional Defiant Disorder

Scientific basis and implications for education.

Exceptional Children, 60, 108-117.


